Dear Patient:

Our primary goal is to provide the very best medical care to all our patients in a setting that is comfortable and convenient. We would like to know how you feel about our medical services, patient care, our physicians and staff members. Your comments will help us to be responsive to your needs. Thank you for your assistance.

PLEASE RATE THE FOLLOWING:

A. YOUR APPOINTMENT:

1. Ease of making appointments by phone Excellent
2. Appointment available within a reasonable amount of time Excellent
3. Getting care for illness/condition as soon as you require it Excellent
4. The efficiency of the check in process Excellent
5. Waiting time in the reception area Excellent
6. Waiting time in the exam room Excellent
7. Keeping you informed if your appointment is delayed for more than 15 minutes Excellent
8. Receipt of Referrals when needed Excellent

B. OUR STAFF:

1. Courtesy of the person who took your call Excellent
2. Courtesy of the receptionist Excellent
3. Courtesy of the nurses and medical assistants Excellent
4. The helpfulness of the people in our business office Excellent

C. OUR COMMUNICATION WITH YOU:

1. Your phone calls answered promptly Excellent
2. Getting advice or help when needed during office hours Excellent
3. Explanation of your procedure (if applicable) Excellent
4. Your test results reported in a reasonable amount of time Excellent
5. Effectiveness of our health information materials/pamphlets Excellent
6. Your ability to obtain prescription refill by phone Excellent

D. YOUR VISIT WITH THE PROVIDER:

(Doctor, Nurse Practitioner, Physical Therapist, Chiropractor, etc.)

1. Willingness to listen and answer and answer your questions Excellent
2. Explaining things in a way you could understand Excellent
3. Instructions regarding medication/follow-up care Excellent
4. The thoroughness of the examination Excellent
5. Information given to you on ways to stay healthy Excellent
6. The quality of your medical care Excellent
7. Overall rating of care for your personal doctor or nurse Excellent

E. OUR FACILITY:

1. Hours of operation convenient for you Excellent
2. Overall comfort (temperature, lighting, etc.) Excellent
3. Adequate parking Excellent

4. Signage and directions easy to follow Excellent

IF AN AUTOMATED PHONE SERVICE WAS UTILIZED FOR PHARMACY REFILLS WOULD YOU USE IT?

☐ **Yes** ☑ **No**

WOULD YOU RECOMMEND THE PROVIDER TO OTHERS

☐ **Yes** ☑ **No**

IF NO, PLEASE TELL US WHY:

IF THERE IS ANY WAY WE CAN IMPROVE OUR SERVICES TO YOU, PLEASE TELL US ABOUT IT:

SOME INFORMATION ABOUT YOU:

YOUR AGE: _____

ARE YOU: A new patient ☐ A returning patient ☑

Submit